Administration of Medication Consent Form & Allergy Action Plan

A. Parent/Guardian to Complete

Student Name: _____ Grade: _____ DOB: _____

Emergency Contact: _____ Emergency Contact phone number_____

I authorize the school nurse or designated staff to administer prescribed medication or treatment to my child at school as directed by the physician below. I will supply the medication in its original, pharmacy-labeled container. In accordance with the Nurse Practice Act, I also grant permission for the school nurse to communicate with the prescribing healthcare provider to ensure safe and effective care. This includes discussion of the prescription or treatment, its implementation at school, my child's response, and any relevant health information related to the medical indication for the medication.

Parent/Guardian Signature: _____ Print Name:_____ Date: _____

B. Physician/Medical Provider to Complete

Severe Allergy To: _____

Reaction	Symptoms	Action
Ingestion or exposure to an allergen	☐If checked, give epinephrine immediately for ANY symptoms if likely eaten. ☐If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.	**OR** Proceed to "Mild Reactions" & "Moderate to Severe Reactions"
Mild Allergic Reaction *There is a greater chance for a Severe Reaction if the student is an asthmatic*	**One** of the following: · Nose: runny or itchy, sneezing · Mouth: Lips, tongue, or mouth: itches and/or tingles, · Skin: few hives · Gut: mild nausea, vomiting, or pain *If **two or more** Mild Reactions proceed to Moderate to Severe Reaction-**Give Epinephrine**	• **Give antihistamine** • Observe the Student closely **Note**: • The severity of symptoms can quickly change • If symptoms become worse or additional symptoms appear, give Epinephrine and follow *Moderate to Severe Reaction*
Moderate to Severe Reaction (Anaphylaxis)	**Any of the following:** · Throat feels tight · Lips or tongue swell · Voice is hoarse · Wheezing or coughing · Trouble breathing · Hives or redness all over the body · Hard to swallow · Fast or weak pulse · Vomiting · Syncope · Agitation · Feelings of Doom	• **Give epinephrine** in the mid-outer thigh-hold 5 seconds • **CALL 911** • If symptoms don't improve in **5 minutes, give a second dose** of epinephrine • Give **antihistamine/inhaler** if ordered • Call parents/guardian

Medications/Doses (Circle)

Epinephrine	Intramuscular -Inhale	**Epi Pen**: 0.15 mg 0.3 mg	**Auvi Q**: 0.1mg 0.15 mg 0.3 mg	**Neffy:** Nasal spray 1mg 2mg	**Other:**
Antihistamine	Oral	**Cetirizine (Zyrtec):** 2.5 mg 5 mg 10 mg	**Diphenhydramine (Benadruyl):** 6.25 mg 12.5 mg 25 mg 50mg		**Other:**
Inhaler	Inhale	**Bronchodilator** as directed:			**Other:**

Signature of Provider: _____ Print Name: _____ Date: _____

Address: _____ Phone: _____